STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK CONVALESCENT CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 7/14/2015 through 7/16/2015. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this 80 certified bed facility was 72 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1-13 and 19) and 5 closed record reviews (Residents 14-18). One complaint was investigated during the survey.	F 000	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	The dates of completion serve as my allegation of compliance. 1. Resident #15 no longer resides at the facility. The medical record for resident #11 was reviewed for the past 30 days to ensure that the physician has been notified of any change in condition in a timely manner. 7/24/15 2. The Director of Nursing/Designee has reviewed all incidents for the past 30 days to ensure the responsible party has been notified in a timely manner. The Director of Nursing/Designee has reviewed the medication administration records for all current resident from the past 30 days to ensure the physician has been notified of any medications that have not been administered due to the resident's refusal. 8/27/15 & ongoing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Nursing Home Administrator — (X6) DATE: 8/10/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for 2 residents (Resident #15 and #11) of 19 residents in the survey sample, to notify the responsible party and the physician in a timely manner of a change in condition.

1. For Resident #15 , the facility staff failed to notify the Responsible Party (RP) of a resident to resident altercation and a fall in a timely manner.

2. Resident #11 refused 14 doses of her daily physician ordered Miralax (a medication for constipation) in June 2015 and 13 doses in July 2015. Resident #11's physician was not informed the Miralax was not being administered due to the resident's refusals.

The findings included:

1. Resident #15 was admitted to the facility on 10/7/14 with the diagnoses of, but not limited to, Alzheimer's Dementia, encephalopathy and hypertension. Resident #15 was discharged to

F 157 The Assistant Director of Nursing/Designee will be responsible for ensuring the responsible party has been notified of incidents in a timely manner. The charge nurse on each shift will be responsible for ensuring that the physician is notified if residents are refusing medications.

3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator on " Responsible Party and Physician Notification". The inservice includes but is not limited to timely notification of the responsible party and physician regarding changes in condition and incidents. — 8/27/15 & ongoing

4. The Director of Nursing/Designee will monitor 100% of incident reports for six weeks to ensure that the responsible party has been notified of incidents. The Director of Nursing/Designee will monitor 20% of medication administration records for 6 weeks to ensure the physician has been notified of medications that have not been administered due to resident refusal. Any trends or variances will be reviewed and addressed. The findings will be reported to the CQI committee on at least a quarterly basis. — 8/27/15 & ongoing

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the hospital on 10/26/14 due to shaking, removing clothes, high blood pressure and holding her chest. Being Resident #15 was not in the facility during the survey a closed record review was conducted.

The most recent Minimum Data Set (MDS) was an initial assessment with an Assessment Reference Date of 10/14/14. The MDS coded Resident #15 with severe cognitive impairment; required set up only for all activities of daily living except eating which Resident #15 required no physical assistance; physical behaviors directed towards others and other behaviors not directed toward others; wandering daily that significantly intruded on the privacy or activities of others. Resident #15 was coded with a fall without injury that occurred prior to admission to the facility.

On 7/15/15 at 1:50 p.m., Resident #15's clinical record was reviewed. The review revealed the following electronic "Clinical Notes:"

Clinical Notes dated 10/24/14 at 12:14 p.m. written by the Director of Nursing (Admin-C) with an effective date (date of occurrence) of 10/23/14 at 8:30 p.m. read: "Resident was struck in the face by another resident. Complete head to toe assessment was done with no evidence of injury. No redness or bruising noted. MD (medical doctor) made aware."

Clinical Notes dated 10/26/14 at 4:48 p.m. written by LPN-A with an effective date of 10/25/14 at 4:46 p.m. read: "resident found on floor by aide on hands and knees no injury or pain noted at this time md (medical doctor) made aware vitals normal left message for rp (responsible party) to call back." There were no post fall assessments

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documented in the clinical record.

Clinical Notes written by the Director of Nursing dated 10/27/14 at 11:38 a.m. with an effective date of 10/24/14 read: "RP made aware of incident that occurred on 10/23/14."

On 7/15/15 at 4:15 p.m. the Administrator and Director of Nursing were asked to present the fall investigation and/or Facility Reported Incident (FRI) reviews for the resident to resident altercation.

On 7/16/15 at 8:40 a.m. the FRI concerning the resident to resident abuse incident was reviewed and deemed complete. The facility fall investigation from 10/25/14 was reviewed and included a nursing assistant statement which revealed the resident was found on knees on floor; resident stated she fell and was already attempting to stand up when nursing assistant approached resident; assisted to bed; called nurse and reported it (fall). An investigation note written by LPN-A included a "Raised area noted to left side of forehead." At 10:00 a.m. a message was left on LPN-A's voice mail to call surveyor back. LPN-A did not return surveyor's call.

An interview was conducted with the Director of Nursing (Admin-C) with the Administrator present, on 7/16/15 at 11:05 a.m. When asked if the family was notified at the time of the fall, Admin-C stated "The family was not notified at the time of fall." When asked about family (RP) notification of the resident to resident altercation, Admin-C stated, "The family was notified of the resident to resident altercation that occurred on 10/23/14." Informed Admin-C the only documented RP

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notification regarding the resident to resident altercation was written by her, entered in the clinical record on 10/27/14 with an effective date of 10/24/14 which was the day after the altercation. When copies of the internal investigation was requested, Admin-C declined to provide a copy. When asked what the nursing expectation is for documentation after a fall, Admin-C stated "Post fall, 3 days of documentation including vital signs is expected."

Review of the facility "FALL PREVENTION PROGRAM" included:

Resident Falls:
If a resident experiences a fall, a complete investigation should identify further preventative strategies...
Physician and responsible party should be notified...
Proper documentation should be entered in the "Nurses' Notes" including follow-up and resolution.

The facility staff did not present any further information regarding the findings.

Complaint Deficiency.

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2. Resident #11 refused 14 doses of her daily physician ordered Miralax (a medication for constipation) in June 2015 and 13 doses in July 2015. Resident #11's physician was not informed the Miralax was not being administered due to the resident's refusals.

Resident #11, a female, was admitted to the facility 11/11/13. Her diagnoses included atrial fibrillation, deep venous thrombosis, hypertension, gastroesophageal reflux disease, diabetes, sarcodosis, and peripheral neuropathy

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5/14/15 was coded as a quarterly assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. Resident #11 was also coded as requiring extensive assistance of one to two staff members for her activities of daily living. Resident #11 was always incontinent of urine and bowel. Section H, H0600. Bowel Patterns, was coded as no constipation present.

Review of the comprehensive care plan revealed a plan of care dated 3/25/15 for Constipation Risk, "Resident is at risk for constipation related to inadequate fluid and fiber in diet; orders for medications known to contribute to constipation, reduced physical mobility, and history of constipation. Under Approaches read, "Provide medications per order".

On 7/16/15 at 11:30, an interview was conducted with Resident #11 while she was sitting outside in her wheelchair. During the interview, Resident #11 stated, "I don't need that Miralax. They [the nurses] prepare and offer it to me, and I just keep

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refusing it." Resident #11 said her bowels were usually very regular, and if she felt constipated she would request some Milk of Magnesia.

Review of Resident #11's clinical record revealed a current signed physician's order, "1/6/15, Miralax 17 grams/dose Powder, Oral Every One Day for Constipation. Mix with 6 ounces water."

Review of the MARs (medication administration records) revealed the following Non -PRN Medication Notes which read:

"June 2015- Miralax refused on 6/9, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/24, 6/26, 6/21, 6/30.

July 2015 - Miralax refused on 7/1, 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/11, 7/12, 7/13, 7/16."

A thorough review of Resident #11's clinical record revealed no documentation Resident #11's physician was informed that Resident #11 was frequently not administered the daily physician ordered Miralax per the resident's request.

On 7/16/15 at 11:45 a.m., the unit manager, RN (registered nurse) A, was interviewed regarding the frequent refusals of Miralax and asked whether the physician was aware. RN A stated, "No, the physician hasn't been notified." RN A said with frequent medication refusals, a PRN (as needed) order from the physician could be an option for Resident #11.

Review of the facility's Medication Administration Guidelines read, "If several doses of a vital medication are withheld or refused, the physician and responsible party are notified and

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F 157	Continued From page 7 documentation of notification is made." The administrator, director of nursing, and corporate consultants were advised of the failure of the staff to inform Resident #11's physician of the frequent refusal of a daily physician ordered medication, 7/16/15 at 12:55 p.m. No additional information was provided.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed for one resident (Resident #4) in a sample of 19 residents, to provide a dignified living experience. 1. Resident #4 was observed being fed a snack of ice cream with the CNA (certified nursing assistant) standing over the resident. The findings included: Resident #4 was admitted to the facility on 10/2/13 with the following diagnoses: Atrial fibrillation, high blood pressure, seizure disorder and stroke. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of	F 241	The dates of completion serve as my allegation of compliance. 1. Resident #4 was assessed with no negative outcomes related to being fed ice cream by a standing staff member. The CNA responsible was reeducated on dignity and respect of individuality. — 7/20/15 2. The Assistant Director of Nursing/Designee has observed resident feeding practices by staff to ensure residents are treated with dignity and respect . The charge nurse on each shift will be responsible for monitoring feeding practices throughout the facility to ensure residents are provided a dignified living experience. — 8/27/15 & ongoing 3. RNs, LPNs and CNAs will be reeducated by the Nursing Education and Training Coordinator on "Dignity and Respect of Individuality". The inservice includes but is not limited to feeding techniques to include sitting while assisting residents with eating and promoting a dignified living experience. — 8/27/15 & ongoing	

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F 241	Continued From page 8 4/30/15 was coded as a quarterly assessment. Resident #4 was coded as having short and long term memory loss, and requiring total assistance with daily decision making. Resident #16 was also coded as requiring extensive to total assistance of one to staff members to perform activities of daily living, such as dressing and eating. Resident #4 was coded as being incontinent of bowel and bladder. On 7/15/15 at 2:50 PM, Resident #4 was observed in the activities room for ice cream. The resident's clinical record noted the resident needs to have supervision for all meals due to choking. CNA (A) was feeding ice cream to the resident, standing over her while spooning the ice cream into her mouth. On 7/15/15 at 2:55 PM, CNA (A) was asked about feeding the resident. CNA (A) stated, "I thought about it (sitting down) but I didn't want to get in trouble for sitting down in the dining room. I thought about it." Review of the facility's "Quality of Life Policy" read as followed: "The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. On 7/16/15 at 12:15 PM, the facility Administrator and DON (director of nursing) were notified of above findings.	F 241	4. The Assistant Director of Nursing/Designee will monitor five feeding activities, which includes mealtime, per week for six weeks to ensure that staff are not providing feeding assistance while standing up. The Director of Nursing/Designee will review findings and report any trends or variances to the CQI committee on or at least a quarterly basis.	8/27/15 & ongoing
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278	The dates of completion serve as my allegation of compliance.	

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F 278	Continued From page 9 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (Minimum Data Set) RAI (Resident Assessment Instrument) for one resident (Residents #2) in a survey sample of 19 Residents. For Resident #2, the facility staff failed to code Glaucoma as an Active Diagnosis.	F 278	1. The MDS for Resident #2 with an ARD of 6/18/15, Section I, Active diagnosis I65000 was corrected to reflect the diagnosis of Glaucoma. The MDS coordinator was reeducated on the importance of coding all active diagnosis on the MDS. 2. All MDSs completed within the past 30 days were reviewed for accuracy of Section I. Any discrepancies were noted and corrected. The MDS coordinator will be responsible for ensuring the accuracy of Section I to reflect active diagnosis. 3. The corporate MDS coordinator reeducated the facility MDS coordinator on Section I. The inservice included a review of the RAI manual instructions for coding section I. The MDS coordinator will be receiving additional MDS training to include enrollment in a RAC certification course. 4. The Assistant Director of Nursing/Designee will review 20% of MDSs completed weekly for six weeks to ensure accuracy of Section I. The Director of Nursing/Designee will review findings and report any trends or variances to the CQI committee on or at least a quarterly basis.	7/24/15 8/27/15 & ongoing 8/27/15 & ongoing 8/27/15 & ongoing

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The findings included:

Resident #2, a male, was admitted to the facility 07/12/2009 and readmitted after hospitalization on 03/02/2010. His diagnoses included Alzheimer's, Parkinson's, atrial fibrillation, anxiety depression, cataracts and glaucoma.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/18/15 was coded as a quarterly assessment. He was coded as having short and long term memory problems and as having severely impaired decision making skills. Resident #2 was also coded as requiring total assistance of one to two staff members for all of his activities of daily living. Resident #2 was coded incontinent of urine and bowels. Section B. Hearing, Speech and Vision, B1000. Vision, was coded highly impaired, object identification in question, but eyes appear to follow objects. Section I- Active Diagnosis, I65000 Vision, was not coded for Cataracts or Glaucoma.

Resident #2 was observed in his room in bed being fed by a CNA (certified nursing assistant) on 7/15/15 at 8:15 a.m. Resident #2 was observed following requests to open his mouth and moaning as he tasted his food. Resident #2's eyes were open, clear with no sign of infection or drainage.

A review of the Resident's clinical record revealed a comprehensive care plan with the following plan of care and interventions dated 6/10/14: "Cataracts - pt. (patient) not a good candidate for cataract surgery. Glaucoma by history - monitor IOP (interocular pressure)."

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Review of Resident#2's MARs (medical administration records) revealed the daily administration of physician ordered eye drops, "Carteolol HCL 1% (1 drop) Drops Both Eyes, one time daily - Glaucoma."

"Carteolol hydrochloride is one of a group of drugs called beta-blockers which can help to reduce pressure in the eye. Teoptic is used to treat conditions such as glaucoma (increased pressure in the eye)." Drugs.com

Further review of the clinical record revealed two Eye Exam consults, Summary Ocular Progress Notes:
"3/5/15 - Diagnosis and Treatment: Glaucoma-Open Angle--Glaucoma by History--IOP remains well-controlled by meds (medications),-continue Ocupress OU (both eyes) q (every a.m. --monitor IOP 6 months."

"6/4/15 - Diagnosis and Treatments: 1. Glaucoma-Open Angle--Glaucoma by History--IOP remains well-controlled by meds,-continue Ocupress OU (both eyes) q (every a.m. --monitor IOP 6 months. 2. Nuclear Sclerotic Cataract--Cataracts-OU-Mild/stable--not visually significant--monitor 6 months. Next Examination September 2015 for Glaucoma follow-up."

On 7/16/15 at 9:40 a.m., an interview was conducted with the (DON) Director of Nursing regarding the exclusion of Glaucoma and Cataracts as an Active Disease on the recent significant change MDS with an ARD date of 3/20/15 and the quarterly assessment date of 6/18/15. After reviewing Resident #2's clinical

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F 278	Continued From page 12 record, the DON provided copies of MDS modifications to reflect the coding of Cataracts and Glaucoma under the Vision section of the Active Diagnoses for Resident #2's MDSs with ARD 3/20/15 and 6/18/15." The Long Term Care RAI User Manual, Chapter 3, page I-7 provides the following guidance, "Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug' s effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease. -- It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice" The administration was informed of the findings, 7/16/15 at 1:00 p.m.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	The dates of completion serve as my allegation of compliance.	

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F 281	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for 2 residents (Resident #15 and #2) of 19 residents in the survey sample, to follow professional standard of nursing. 1. For Resident #15 , the facility staff failed to adequately document, assess and monitor Resident #15 after a fall. 2. For Resident #2, the facility staff failed to document two doses of Omeprazole (for gastroesophageal reflux disease, GERD) as having been administered. The findings included: 1. Resident #15 was admitted to the facility on 10/7/14 with the diagnoses of, but not limited to, Alzheimer's Dementia, encephalopathy and hypertension. Resident #15 was discharged to the hospital on 10/26/14 due to shaking, removing clothes, high blood pressure and holding her chest. Being Resident #15 was not in the facility during the survey, a closed record review was conducted. The most recent Minimum Data Set (MDS) was an initial assessment with an Assessment Reference Date of 10/14/14. The MDS coded Resident #15 with severe cognitive impairment; required set up only for all activities of daily living except eating which Resident #15 required no physical assistance; physical behaviors directed towards others and other behaviors not directed	F 281	1. Resident #15 no longer resides at the facility. Resident #2 has been assessed and there were no negative outcomes related to missed medication documentation. The nurses responsible have been reeducated on the importance of documentation of assessment and monitoring post fall. The medication nurses have been reeducated on the importance of documentation of medication administration. 2.The Director of Nursing/Designee will review all falls that have occurred in the past 30 days to ensure that the assessment and monitoring of the resident post fall is adequately documented in the medical record. The Director of Nursing/Designee will review all medication administration records of current residents for the past 30 days to ensure that all medications have been administered as ordered and that administration is documented on the medication administration record. Any variances will be investigated and corrective action initiated. The Assistant Director of Nursing/Designee will be responsible for ensuring the medical record adequately reflects the assessment and monitoring of the resident post fall. The medication nurses on each shift will be responsible for ensuring facility policy and professional standards are followed for the administration of medications.	7/24/15 8/27/15 & ongoing

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F 281	Continued From page 14 toward others; wandering daily that significantly intruded on the privacy or activities of others; had one fall without injury prior to admission. On 7/15/15 at 1:50 p.m., Resident #15's clinical record was reviewed. The review revealed the following electronic "Clinical Notes:" Clinical Notes dated 10/26/14 at 4:48 p.m. written by LPN-A with an effective date (date of occurrence) of 10/25/14 at 4:46 p.m. read: "resident found on floor by aide on hands and knees no injury or pain noted at this time md (medical doctor) made aware vitals normal left message for rp (responsible party) to call back." There were no post fall nursing assessments in the clinical record. On 7/15/15 at 4:15 p.m. the Administrator and Director of Nursing were asked to present the fall investigation related to the fall that occurred on 10/25/14. On 7/16/15 at 8:40 a.m. the facility fall investigation from 10/25/14 was reviewed and included a nursing assistant statement which included the resident was found on knees on floor; resident stated she fell and was already attempting to stand up when nursing assistant approached resident; assisted to bed; called nurse and reported it (fall). An investigation note written by Licensed Practical Nurse (LPN) -A included a "Raised area noted to left side of forehead." At 10:00 a.m. on 7/16/15 in attempt to interview LPN-A, a message was left on LPN-A's voice mail to call surveyor back. LPN-A did not return surveyor's call. The Director of Nursing's incident report review dated 10/27/14 listed "Nature of injury-hematoma" but no body part was	F 281	3. All RNs/LPNs will be reeducated by the Nursing Education and Training Coordinator regarding fall and medication administration documentation. The inservice will include but is not limited to adequate post fall assessment, monitoring and documentation. It will also include the importance of completion of medication administration documentation. 4. The Director of Nursing/Designee will monitor 20% of falls weekly for six weeks to ensure the medical record adequately reflects the assessment and monitoring of the resident post fall. The Assistant Director of Nursing/Designee will audit 10% of medication administration records weekly for six weeks to ensure that medications have been administered as ordered and documented on the medication administration record. The Director of Nursing/Designee will review findings and report any trends or variances to the CQI committee on or at least a quarterly basis.	8/27/15 & ongoing 8/27/15 & ongoing

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documented.

An interview was conducted with the Director of Nursing (Admin-C) with the Administrator present, on 7/16/15 at 11:05 a.m. When asked if the family was notified at the time of the fall, Admin-C stated "The family was not notified at the time of fall." When asked what the nursing expectation was for documentation after a fall, Admin-C stated "Post fall, 3 days of documentation including vital signs is expected." The Administrator and Director of Nursing were informed of the lack of post fall assessments and monitoring including lack of documentation in the clinical record of the injury to Resident #15's left forehead. Admin-C stated the facility did not have a fall policy but did provide a facility fall prevention program document.

Review of the facility document titled "FALL PREVENTION PROGRAM" included:

Resident Falls:
If a resident experiences a fall, a complete investigation should identify further preventative strategies...
Physician and responsible part should be notified...
Proper documentation should be entered in the "Nurses' Notes" including follow-up and resolution.

Guidance given from Potter Perry Fundamentals of Nursing, Eighth Edition, page 216 included: "The data from a hands-on physical assessment allow you to collect valuable objective information needed to form accurate diagnostic conclusions. Always conduct an examination competently with a caring and culturally sensitive approach." And

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page 217 included: "Data documentation is the last part of a complete assessment. The timely, thorough, and accurate documentation of facts is required in recording patient data. If you do not record an assessment finding or problem interpretation, it is lost and unavailable to anyone else caring for the patient....Observing and recording patient status are legal and professional responsibilities."

The facility staff did not present any further post fall assessments or information regarding the findings.

Complaint Deficiency.

2. For Resident #2, the facility staff failed to ensure two doses of Omeprazole (for gastroesophageal reflux disease) were documented as having been administered.

Resident #2, a male, was admitted to the facility 7/12/09 and readmitted after hospitalization on 3/2/10. His diagnoses included Alzheimer's, Parkinson's, cataracts, glaucoma, Blepharitis, and GERD (gastroesophageal reflux disease) .

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/18/15 was coded as a quarterly assessment. He was coded as having short and long term memory problems and as having severely impaired decision making skills. Resident #2 was also coded as requiring total assistance of one to two staff members for all of his activities of daily

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living. Resident #2 was coded incontinent of urine and bowels.

A review of the clinical record revealed a physician order dated 4/20/15 for Resident #2 to be administered Omeprazole (Prilosec), 20 milliequivalents/5 milliliters suspension, by mouth for GERD once a day.

Resident #2's July 2015 MAR (medication administration record) revealed on 7/09/15 and 7/10/15, Prilosec was not documented as having been administered. For the dates in question, equal signs "=" were documented on the MAR. According to the MAR Legend, "=" indicated the medication was Previously Scheduled. There was no documentation regarding Prilosec on 7/9/15 or 7/10/15 on the NON PRN Medication Notes to explain the significance of the "=" signs.

An interview was conducted with the DON on 07/16/15 at approximately 9:30 a.m. After reviewing the clinical record, the DON said there was no way of knowing if the Prilosec was administered on 7/9/15 or 7/10/15. The DON added, "The expectation would be for the nurse to put in her initials after administering a medication." The DON said she was unable to contact the two nurses responsible for documenting the "=" signs on the MAR for the dates in question.

The facility administration cited the use of numerous different professional nursing resources for developing their professional standards for nursing. A specific professional nursing reference was not cited.

Review of the facility's Medication Administration

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F 281	Continued From page 18 policy read, "The resident's MAR/TAR (Treatment Administration Record) is initialed by the person administrating a medication in the space provided under the date, and on the line for that specific medication dose administration. Guidance regarding medication documentation was given to nursing by "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form."	F 281		
F 283 SS=D	483.20(i)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed for 1 resident (Resident #14) of 19 residents in the survey sample to ensure a discharge summary was completed. The findings included: Resident # 14, an 80 year old, was admitted to the facility on 12/10/14. Her diagnoses included dementia and depression.	F 283	The dates of completion serve as my allegation of compliance. 1. The discharge summary has been completed for resident #14 and filed in the resident's discharge record. — 7/24/15 2. The Director of Nursing/Designee will review clinical records of all discharged residents for the past 30 days to ensure the discharge summary has been completed and is located in the closed record. The Director of Nursing/Designee will be responsible for ensuring discharge summaries have been completed in accordance with facility policy. — 8/27/15 & ongoing 3. Physicians and providers will be reeducated on the importance of completing the discharge summary. The inservice includes but is not limited to content required for a complete and accurate discharge summary, timeliness of completion and review of the facility's policy. — 8/27/15 & ongoing	

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F 283	Continued From page 19 Her most recent Minimum Data Set assessment was an initial assessment. Resident #14 was coded with a Brief Interview of Mental Status score of 6 indicating severe cognitive impairment. She required extensive assistance with her activities of daily living. Resident #14 was discharged from the facility on 1/22/15. Both the electronic and paper parts of the clinical record were reviewed. The closed record did not include a discharge summary. On 7/16/16 at 11:00 a.m., the Director of Nursing stated that she had checked with the physician's office and found that a discharge summary had not been completed.	F 283	4. The Director of Nursing/Designee will review the medical record of all residents who have been discharged from the facility weekly for six weeks to ensure that the discharge summary has been completed. The Director of Nursing/Designee will review findings and report any trends or variances to the CQI committee on or at least a quarterly basis.	8/27/15 & ongoing
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed for 2 resident (Resident #3 and Resident #2) of 19 residents in the survey sample to ensure physician orders were followed. 1. Resident #3 received insulin coverage in the evening instead of at dinner time and insulin was	F 309	The dates of completion serve as my allegation of compliance. 1. Resident # 3 was assessed with no negative outcomes related to administration of insulin. Resident # 2 was assessed with no negative outcomes related to eye treatment. The physician and the responsible parties were notified. The insulin order was corrected immediately and the eye treatment was reordered by the primary physician. The nurse involved was reeducated on scheduling of insulin orders in the EHR. The nurse involved with the eye treatment was reeducated on review of consultation notes.	7/24/15

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F 309	Continued From page 20 not held per physician order. 2. For Resident #2, the facility staff failed to implement and perform a physician ordered eye treatment. The findings included: 1. Resident #3, a 91 year old, was admitted to the facility on 11/2/12. His diagnoses included diabetes and congestive heart failure. Resident #3's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/6/15. He was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with his activities of daily living. Resident #3's clinical record was reviewed. A note from the Nurse Practitioner dated 1/15/15 read "Problem: BS (blood sugar) uncontrolled Dx (diagnosis) HX (history) of DM (Diabetes Mellitus), On Lantus 65 U (unit) qd AM (every morning) Lantus 38 U SQ (subcutaneous) q pm (every night) Humalog 10 U SQ (subcutaneous) at lunch + dinner if BS (blood sugar) > 180". "1) D/C (discontinue) Humalog 10 U (unit) with lunch and dinner if BS (blood sugar) >180 2) Humalog 13 U (units) SQ (subcutaneous) with lunch and dinner if BS (blood sugar) > 180". A note written by the Physician Assistant on 7/2/15 included insulin orders in the "Medication List" section of the note. The insulin orders read: 1) Lantus 65 units subcutaneous daily 2) Humalog 10 units twice a day before lunch and	F 309	2. The Director of Nursing/Designee has reviewed the medication administration records of current residents for the past 30 days to ensure that all insulin orders are accurate and have been scheduled in accordance with the physician order. The Director of Nursing/Designee has reviewed all ophthalmology progress notes for current residents within the last 30 days to ensure all new orders have been implemented. 3. RNs/LPNs will be reeducated on order entry and review of consultation notes. The inservice will include but is not limited to proper scheduling of insulin according to the physicians order and the importance of reviewing all consulting physicians progress notes to ensure orders are initiated as ordered. 4. The Director of Nursing/Designee will audit 20% of all new insulin orders weekly for six weeks to ensure insulin has been scheduled according to the physicians order. The Director of Nursing/Designee will audit 20% of all ophthalmology consultation notes weekly for six weeks to ensure any and all new orders are implemented and performed. The Director of Nursing/Designee will review findings and report any trends or variances to the CQI committee on or at least a quarterly basis.	8/27/15 & ongoing 8/27/15 & ongoing 8/27/15 & ongoing

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dinner
3) Lantus 35 units every afternoon.

Included in the "Plan" section read "1. DM II (Diabetes Mellitus, type 2)- stable, continue insulins, routine HgbA1c (blood sugar test) monitoring".

Resident #3's July 2015 Medication Administration Record (MAR) was reviewed. Included was Humalog 13 units Subcutaneous two times daily starting 3/26/15. The order included a parameter that read "If BS (blood sugar) is greater that 180 at lunch & dinner then give 13 u (units)." The administration times for the Humalog on the MAR were "Midday Medpass 12-2 p.m." and "Evening Med pass 8-10 p.m."

In addition to the Humalog being administered at the evening medpass rather than at the dinner med pass, parameters were not followed during the evening med pass. For the month of July 2015, 13 units of Humalog were administered on 11 occasions when Resident #3's blood sugar was less than 180 and should have been held.

The 11 dates and blood sugar readings were documented on the July 2015 MAR during the " Evening Med-Pass 8-10 pm " as follows:
7/1/15= 112 milligrams/deciliter
7/4/15= 89
7/5/15= 176
7/6/15= 170
7/7/15= 134
7/9/15= 132
7/10/15= 168
7/11/15= 86
7/12/15= 123
7/13/15= 91

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Parameters were followed appropriately for the lunch time Humalog administration. On 7/16/15 at 10 a.m., Registered Nurse A (RN A) was asked how the nurses documented that a medication was held. She stated that the system would prompt them to choose a code or to write a note.

On 7/15/15 at the end of day meeting, the Director of Nursing (DON) was asked why Resident #3 received Humalog at the evening med pass when the order specified that the Humalog should be given with lunch and dinner. It was reviewed with the DON that on 7/2/15 the Physician Assistant charted that Resident #3 was receiving 10 units of Humalog and should continue with that dose. The DON was also notified that parameters were not followed. The DON was asked to clarify when the Humalog should be given and at what dose.

On 7/16/15 at 10:00 a.m. the DON stated that the Humalog order was supposed to be 13 units at lunch and dinner. She stated that the order had been input into the system incorrectly.

Resident #3's most recent Hemoglobin A1c (average of the blood glucose level over a 3 month period) labwork was completed on 7/8/15 with a reading of 6.9%. There were no apparent adverse effects from the insulin administration errors. A reading of 6.5% or above indicates

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diabetes with a desired level below 7.%.

http://www.niddk.nih.gov/health-information/health-topics/diagnostic-tests/a1c-test-diabetes/Pages/index.aspx

The Administrator and Director of Nursing were notified of the issues with the diabetic management and medication error at the end of day meeting on 7/16 15.

2. For Resident #2, the facility staff failed to implement and perform a physician ordered eye treatment.

Resident #2, a male, was admitted to the facility 7/12/09 and readmitted after hospitalization on 3/2/10. His diagnoses included Alzheimer's, Parkinson's, cataracts, glaucoma, Blepharitis, and GERD (gastroesophageal reflux disease) .

"Blepharitis is inflammation of the eyelids. Even with successful treatment, the condition frequently is chronic and requires daily attention with eyelid scrubs."
www.mayoclinic.org/diseases-conditions/blepharitis

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/18/15 was coded as a quarterly assessment. He was coded as having short and long term memory problems and as having severely impaired decision making skills. Resident #2 was also coded as requiring total assistance of one to two staff members for all of his activities of daily living. Resident #2 was coded incontinent of

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urine and bowels. Section B. Hearing, Speech and Vision, B1000. Vision, was coded highly impaired, object identification in question, but eyes appear to follow objects.

Resident #2 was observed in his room in bed being fed by a CNA (certified nursing assistant) on 7/15/15 at 8:15 a.m. Resident #2 was observed following requests to open his mouth and moaning as he tasted his food. Resident #2's eyes were open, clear with no sign of infection or drainage.

A review of Resident #2's clinical record was conducted during the survey. The comprehensive care plan (effective 1/15/2015 - Present) included a plan of care which read, "Vision: Resident ability to see adequate light is Highly Impaired, +Glaucoma, History of Blepharitis. Administer eye medications as ordered."

The clinical record review revealed the following treatment orders following two Eye Exam consultations:
" Summary Ocular Progress Notes-
"3/5/15 - Diagnosis and Treatment:
1. Glaucoma-Open Angle--Glaucoma by History--IOP remains well-controlled by meds,-continue Ocupress OU (both eyes) q (every a.m. --monitor IOP 6 months.

2. Blepharitis Squamous --Blepharitis-OU-mild/moderate--Initiate Tobradex ophth susp: 1 gtt (drop)-QID (4 times a day)-OU x 10 days, then Artificial tears: 1 gtt-BID(twice a day) - OU--continue daily lid scrubs--monitor 1-2 months. Next Examination: April 2015 for Lid Check. The nurse practitioner 's signature and

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date (9/22/14) were written on the consult

6/4/15 - Diagnosis and Treatments:
1. Glaucoma-Open Angle--Glaucoma by History--IOP remains well-controlled by meds,-continue Ocupress OU (both eyes) q (every a.m. --monitor IOP 6 months.

2. Blepharitis Squamous --Blepharitis-OU-mild/moderate--Continue Artificial tears: 1 gtt (drop)-QID-OU x 10 days, then Artificial tears: 1 gtt-BID(twice a day) - OU--continue daily Lid Scrubs--monitor 6 months.

3. Nuclear Sclerotic Cataract--Cataracts-OU-Mild/stable--not visually significant--monitor 6 months. Next Examination September 2015 for Glaucoma follow-up."

A review of Resident #2's (MARs) Medication Administration Record revealed the physician ordered eye drops had been administered as ordered. Review of the March, April, May, June and July 2015 TARs (Treatment Administration Records) did not reveal the physician ordered treatment for daily Lid Scrubs.

When interviewed about the physician ordered Lid Scrubs on 7/15/15 at 15:30 p.m., the DON provided a copy of an Eye Exam dated 9/18/14 with a physician's order for the Lid Scrubs: "Blepharitis OU--Continue Lid Scrubs with dampened wash cloth in diluted baby shampoo (4 to 8 drops of baby shampoo in 1/2 cup of water) q (every) am OU (both eyes) indefinitely. " The nurse practitioner 's signature and date (9/22/14) were written on the consult. The DON requested time to review Resident#2's clinical record to see if the Lid Scrubs were ever implemented.

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On 7/16/16 at 11:45 a.m., after reviewing the clinical record, the DON said there was no documentation the physician ordered treatment for daily Lid Scrubs was ever initiated or performed. The DON stated, "I contacted the physician to see if he want him (Resident#2) to have the Lid Scrubs. The doctor wanted to reinstate the Lid Scrubs." The following physician order was provided, "7/16/15, LID SCRUB COMPLIANCE with Lint Free Pads, Both Eyes. One Time Daily Starting 7/16/2015. Instructions: Clean with baby shampoo and warm soapy water."

The DON was unable to provide evidence the physician's order for Lid Scrubs ordered on 9/22/14, and reordered to be continued on 3/5/15 and again on 6/4/15, was ever implemented by the facility staff.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; page 419 stated, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

F 333 SS=D 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

F 333 The dates of completion serve as my allegation of compliance.

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility

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F 333	Continued From page 27 documentation review and clinical record review the facility staff failed for 1 resident (Resident #3) of 19 residents in the survey sample to ensure residents were free from significant medication errors. 1. Resident #3 received insulin coverage in the evening instead of at dinner and insulin was not held on 11 occasions as per physician ordered parameters. The findings included: 1. Resident #3 received insulin coverage in the evening instead of at dinner and insulin was not held per physician ordered parameters. Resident #3, a 91 year old, was admitted to the facility on 11/2/12. His diagnoses included diabetes and congestive heart failure. Resident #3's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/6/15. He was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with his activities of daily living. Resident #3's July 2015 Medication Administration Record (MAR) was reviewed. Included was Humalog 13 units Subcutaneous two times daily starting 3/26/15. The order included a parameter that read "If BS (blood sugar) is greater that 180 at lunch & dinner then give 13 u (units)." The administration times for the Humalog on the MAR were "Midday Medpass 12-2 p.m." and "Evening Med pass 8-10 p.m." The evening Humalog should have been	F 333	1. Resident #3 was assessed and has not demonstrated any adverse outcome related to insulin administration. The responsible party and physician have been notified of the medication error. The nurses involved have been reeducated on medication administration to include insulin orders and parameters. 2.The Assistant Director of Nursing/Designee will review 100% of insulin orders for all current residents to ensure that the administration times are consistent with the physicians order. The medication administration records for the past 30 days will be reviewed to ensure that medications have been administered as ordered and held according to parameters, if indicated. The charge nurse on each shift will be responsible for reviewing the insulin orders to ensure they are scheduled according to the physician order. The charge nurse on each shift will review the medication administration records to ensure medications have been administered according to the physician order.	7/24/15 8/27/15 & ongoing

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F 333	Continued From page 28 administered at dinner time. In addition to the Humalog being administered at the evening med (medication) pass rather than at the dinner med pass. Parameters were not followed during the evening med pass. For the month of July 2015, 13 units of Humalog were administered on 11 occasions when Resident #3's blood sugar was less than 180. The Humalog should have been held on these 11 occasions. The 11 dates and blood sugar readings were documented on the July 2015 MAR during the " Evening Med-Pass 8-10 pm " as follows: 7/1/15= 112 milligrams/deciliter 7/4/15= 89 7/5/15= 176 7/6/15= 170 7/7/15= 134 7/9/15= 132 7/10/15= 168 7/11/15= 86 7/12/15= 123 7/13/15= 91 7/14/15= 148 As documented on the MAR, parameters were followed appropriately for the lunch time Humalog administration. On 7/16/15 at 10 a.m., Registered Nurse A (RN A) was asked how the nurses documented that a medication was held. She stated that the system would prompt them to choose a code or to write a note.	F 333	3. RN/LPNs will be reeducated by the Nursing Education and Training Coordinator/Designee on the "Six Rights of Medication Administration". The inservice will include but is not limited to a review of order entry in the EHR to ensure medications are scheduled according to the physician order. It will also include following the physicians order as it pertains to holding medications according to parameters. 4. The Director of Nursing/Designee will review 10% of new orders weekly for six weeks to ensure that medications are scheduled according to the physicians order. The Assistant Director of Nursing/Designee will review 10% of medication administration records weekly for six weeks to ensure medications have been administered or held according to the prescribed parameters. The results of the audits will be reviewed and corrective action taken if needed. The Director of Nursing will report findings to the CQI committee on at least a quarterly basis.	8/27/15 & ongoing 8/27/15 & ongoing

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F 333	Continued From page 29 On 7/15/15 at the end of day meeting, the Director of Nursing (DON) was notified that Resident #3 received Humalog at the evening med pass when the order specified that the Humalog should be given with lunch and dinner. The DON was also notified that parameters were not followed. The DON was asked to clarify when the Humalog should be given and at what dose. On 7/16/15 at 10:00 a.m. the DON stated that the Humalog order is supposed to be 13 units at lunch and dinner. She stated that the times were wrong on the MAR because the order had been input into the system incorrect. Resident #3's most recent Hemoglobin A1c (average of the blood glucose level over a 3 month period) labwork was completed on 7/8/15 with a reading of 6.9%. There were no apparent adverse effects from the insulin administration errors. A reading of 6.5% or above indicates diabetes with a desired level below 7.%. http://www.niddk.nih.gov/health-information/health-topics/diagnostic-tests/a1c-test-diabetes/Pages/index.aspx The Administrator and Director of Nursing were notified of the issues with the diabetic management and medication error at the end of day meeting on 7/16/15.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425	The dates of completion serve as my allegation of compliance.	

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F 425	Continued From page 30 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for one resident (Resident #2) of 19 residents in the survey sample. For Resident #2, the facility staff failed to ensure Omeprazole (for gastrointestinal reflux disease) was available for administration. The findings included: Resident #2, a male, was admitted to the facility 7/12/09 and readmitted after hospitalization on 3/2/10. His diagnoses included Alzheimer's, Parkinson's, atrial fibrillation, anxiety depression, cataracts, glaucoma and gastrointestinal reflux	F 425	1. Resident #2 has been assessed with no negative outcomes related to missed Omeprazole dose. The medication supply has been checked to ensure availability for future doses. The nurses responsible were reeducated on the importance of monitoring expiration dates to ensure medication is reordered timely to avoid missed doses. 2. The Assistant Director of Nursing/Designee has checked the medication supply for all current residents to ensure all medications are available for administration. The medication nurse on each shift will be responsible for ensuring that medications are available for the next scheduled dose and reordering medications prior to expiration date. 3. The Nursing Education and Training Coordinator has reeducated RNs/LPNs on "Pharmaceutical Services". The inservice included but was not limited to a review of the procedure for reordering medication from pharmacy prior to expiration date and checking to ensure an adequate supply is available.	7/24/15 8/27/15 & ongoing 8/27/15 & ongoing

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F 425	Continued From page 31 disease (GERD). Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/18/15 was coded as a quarterly assessment. He was coded as having short and long term memory problems and severely impaired decision making skills. Resident #2 was also coded as requiring total assistance of one to two staff members for all of his activities of daily living. Resident #2 was coded incontinent of urine and bowels. A review of the clinical record revealed a physician order dated 4/20/15 for Resident #2 to be administered Omeprazole (Prilosec), 20 milliequivalents/5 milliliters suspension, by mouth for GERD once a day. A review of Resident #2's July 2015 MAR (Medication Administration Record) revealed Prilosec was not administered on 07/11/15. A note by the medication nurse on 7/11/15 read, "Medication expired. Pharmacy aware. Not Administered." An interview was conducted with the DON (director of nursing) on 07/16/15 at approximately 9:30 a.m. After reviewing the clinical record, the DON said the Prilosec was the liquid form and was expired and the night shift nurse reordered it on 7/11/15. "The Prilosec wasn't available for the scheduled dose on 7/11." The facility administration was informed of the findings during a briefing on 7/16/15 at approximately 12:50 a.m. The facility did not present any further information about the findings.	F 425	4. The Assistant Director of Nursing/designee will review on a weekly for six weeks 10% of all current residents medication supplies to ensure all ordered medications are available for administration. The Director of Nursing will review findings for any trends or variances and report to the CQI committee on at least a quarterly basis.	8/27/15 & ongoing

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F 502 SS=D	Continued From page 32 483.75(j)(1) ADMINISTRATION	F 502		

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed for one of 16 residents (Resident #4) in the survey sample to obtain physician ordered labs.

Resident #4 did not have an hemoccult (testing of stool for hidden blood) times three as ordered by the physician.

The findings included:

Resident #4 was admitted to the facility on 10/2/13 with the following diagnoses: Atrial fibrillation, high blood pressure, seizure disorder, anemia and stroke.

Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/30/15 was coded as a quarterly assessment. Resident #4 was coded as having short and long term memory loss, and requiring total assistance with daily decision making. Resident #16 was also coded as requiring extensive to total assistance of one to staff members to perform activities of daily living, such as dressing and eating. Resident #4 was coded as being incontinent of bowel and bladder.

Review of the clinical record revealed a

F 502

The dates of completion serve as my allegation of compliance.

1. Resident #4's physician was notified regarding the hemocult testing ordered in January was not performed. The physician evaluated the resident's current labs and status and discontinued the order. RNs/LPNs have been reeducated on the process for obtaining and documenting hemocult stool specimens as ordered. — 7/24/15

2. A 100% audit of current residents will be conducted for the past 30 days to identify any variance with ordered labs. The physician will be notified of findings and any change in orders will be completed. The lab tracking log will be reviewed daily by the Charge Nurse/Designee to ensure that labs, including hemocults have been obtained as ordered and that physicians are notified of the results. If there are variances, the physician will be notified. — 8/27/15 & ongoing — 8/27/15 & ongoing

3. RN/LPNs were reeducated by the Nursing Education and Training Coordinator/Designee on obtaining hemocult specimens as ordered and recording results in the medical record.

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F 502	Continued From page 33 physician's order dated 1/12/15 for an iron level, Ferritin level, TIBC (total iron binding capacity) and to check hemoccult stools times three, as the resident was showing signs and symptoms of anemia. The blood samples were obtained on 1/16/15, but no hemoccult stools were noted on the MAR (medication administration record) or in the nurse's notes. On 7/16/15 at 12:15 PM, the DON (director of nursing) stated, "I honestly don't have have any documents to give you."	F 502	4. The Assistant Director of Nursing/Designee will review 20% of the residents scheduled for lab tests weekly for six weeks to ensure that labs have been obtained as ordered by the physician and results are in the medical record. If variances are identified, the physician will be notified. The Director of Nursing will review findings and report any trends or variances to the CQI committee on at least a quarterly basis.	8/27/15 & ongoing

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